Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST - FORT WORTH
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name
New Hampshire Insurance Co.

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4570-01

MFDR Date Received
June 28, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $3,777.36, minus their payment of $2,910.96 there is still an outstanding balance of $867.24."

Amount in Dispute: $867.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier maintains its position as outlined in the original response."

Response Submitted by: New Hampshire Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2009	Outpatient Hospital Services	$867.24	$65.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 26 2010
   - 147 – Provider contracted/negotiated rate expired or not on file.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

- 59 – Processed based on multiple or concurrent procedure rules.
- W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated May 1, 2010

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 59 – Processed based on multiple or concurrent procedure rules.
- 612 – THE REIMBURSEMENT FOR THIS PROCEDURE HAS BEEN CALCULATED ACCORDING TO THE MULTIPLE PROCEDURE RULE FOR RADIOLOGY CHARGES
- 857-000 – CPT/NDC/HCPC/ICD-9 CODES REQUIRED FOR REIMBURSEMENT. PLEASE RESUBMIT WITH APPROPRIATE CODE(S).
- 900-001 – 0-DENIAL AFTER RECONSIDERATION/BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED
- W1 – Workers Compensation State Fee Schedule Adjustment
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Explanation of benefits dated July 12, 2010

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 595-001 – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.
- 59 – Processed based on multiple or concurrent procedure rules.
- 612 – THE REIMBURSEMENT FOR THIS PROCEDURE HAS BEEN CALCULATED ACCORDING TO THE MULTIPLE PROCEDURE RULE FOR RADIOLOGY CHARGES
- 857-000 – CPT/NDC/HCPC/ICD-9 CODES REQUIRED FOR REIMBURSEMENT. PLEASE RESUBMIT WITH APPROPRIATE CODE(S).
- 900-001 – 0-DENIAL AFTER RECONSIDERATION/BASED ON FURTHER REVIEW, NO PAYMENT IS WARRANTED
- 983-001 – UPON FURTHER REVIEW, ADDITIONAL PAYMENT IS WARRANTED
- W1 – Workers Compensation State Fee Schedule Adjustment
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement." Review of the submitted information finds insufficient information to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the dates of service in dispute. The respondent did not submit documentation to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time of the disputed dates of service. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines…,
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier

payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 36415, date of service November 9, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
   - Procedure code 80053, date of service November 9, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.44. 125% of this amount is $19.30. The recommended payment is $19.30.
   - Procedure code 85025, date of service November 9, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.
   - Procedure code 81001, date of service November 9, 2009, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.63. 125% of this amount is $5.79. The recommended payment is $5.79.
   - Procedure code 76376, date of service November 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 96374, date of service November 9, 2009, is unbundled. This procedure is a component service of procedure code 74160 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
   - Procedure code 96375, date of service November 9, 2009, is unbundled. This procedure is a component service of procedure code 74160 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
   - Procedure code 99284, date of service November 9, 2009, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If OPPS criteria are met, this service is assigned to composite APC 8003. Review of the submitted information finds that the criteria for composite payment have not been met. Separate payment is allowed. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate

APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $217.91. This amount multiplied by 60% yields an unadjusted labor-related amount of $130.75. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of $125.23. The non-labor related portion is 40% of the APC rate or $87.16. The sum of the labor and non-labor related amounts is $212.39. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this line is $212.39. This amount multiplied by 200% yields a MAR of $424.78.

- Procedure code J2270, date of service November 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service November 9, 2009, has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.14. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of $0.13. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.23 multiplied by 4 units is $0.92. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total APC payment for this line is $0.92. This amount multiplied by 200% yields a MAR of $1.84.
- Procedure code Q9963, date of service November 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9967, date of service November 9, 2009, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 72125, 72193, 74160, 70450, and 71260, date of service November 9, 2009, have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a “without contrast” CT procedure is performed on the same date of service as a “with contrast” CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which, per OPPS Addendum A, has a payment rate of $635.10. This amount multiplied by 60% yields an unadjusted labor-related amount of $381.06. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of $364.98. The non-labor related portion is 40% of the APC rate or $254.04. The sum of the labor and non-labor related amounts is $619.02. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.224. This ratio multiplied by the billed charge of $9,198.50 yields a cost of $2,060.46. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $619.02 divided by the sum of all APC payments is 74.37%. The sum of all packaged costs is $392.54. The allocated portion of packaged costs is $291.94. This amount added to the service cost yields a total cost of $2,352.40. The cost of these services exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,269.11. 50% of this amount is $634.56. The total APC payment for this line, including outlier payment, is $1,253.58. This amount multiplied by 200% yields a MAR of $2,507.15.

4. The total allowable reimbursement for the services in dispute is $2,976.80. This amount less the amount previously paid by the insurance carrier of $2,911.56 leaves an amount due to the requestor of $65.24. This

amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $65.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $65.24 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.